

Becker et al. (2002) Impact of introduction of Western television on disordered eating patterns among Fijian adolescent girls

- The field study investigated changes in eating patterns in 1995 after television had been introduced to a remote province in Fiji, and again in 1998 when television had been available for three years). The traditional Fiji body ideal at the time was robust and the pressure to be thin found in many Western countries was absent.
- The study used quantitative (survey) and qualitative methods (semi-structured interviews) on issues such as television viewing, dieting, body satisfaction, and purging. Adolescent girls from two secondary schools participated.
- The results showed an increase in dieting and self-induced vomiting to control weight from 0% in 1995 to 11.3% in 1998.
- The researchers suggested that increasing globalization and exposure to Western media could explain the increase in symptoms related to eating disorders in non-Western countries. The specific combination of binge eating and purging to control weight, which is the core symptom of bulimia nervosa, only appeared after introduction of television. This could support that bulimia is a culture-bound syndrome.
- The study did not use clinical diagnoses, which is a limitation. There may be a tendency to report symptoms (e.g. purging) in anonymous self-reports but a clear diagnosis cannot be made. The questionnaires revealed clinical signs (vomiting and body dissatisfaction) associated with eating disorders and in particular bulimia. The study only included girls so nothing can be concluded on changes in eating behaviour among males (sample bias).

Gender variation in prevalence of bulimia

Makino et al. (2004) reviewed studies on eating disorders in 11 Western countries. They found that more female participants suffered from eating disorders and had abnormal eating attitudes than male participants.

Males

- Men are generally less likely to develop eating disorders, perhaps due to less pressure on men to conform to an ideal body weight or shape (Rolss et al. 1991). Men who develop eating disorders tend to resemble females in terms of dissatisfaction with their body (Olivardia et al. 1995).
- Certain sub-populations of men with jobs that require weight restrictions (e.g. wrestlers and jockeys) seem to be at increased risk of developing eating disorders. There may be a possible link between male homosexuality and eating disorders because of a higher emphasis on attractiveness and slimness in gay subcultures (Silberstein et al. 1989).

Females

- There has been a steady increase in diagnosis of bulimia nervosa in the UK from 1988 to 2000 (Currin et al. 2005) but since 1996 there has been a decline. This meta-analysis used data from general practitioners (GPs) in the UK. The study found that incidence of bulimia nervosa per 100 was 94 cases for females and five cases for males. Overall females are more likely to be diagnosed with bulimia than males.
- Currin et al. (2005) found that the highest risk for bulimia nervosa is in young women between 10 and 19. Certain sub-populations such as ballerinas and models have been associated with increased risk for developing eating disorders because of high pressure to be thin.

Examine biomedical, individual and group approaches to treatment

Biomedical treatment of depression

- The biomedical approach to treatment is based on the assumption that if a mental problem is caused by biological malfunctioning, the cure is to restore the biological system with drugs. For example, the serotonin hypothesis of depression suggests that *depression* is linked to low levels of the neurotransmitter serotonin (see unit 5.5). Anti-depressant treatment should therefore aim to regulate serotonin levels.
- Anti-depressants are often used in the treatment of *bulimia nervosa* because some patients also suffer other disorders such as depression (comorbidity).
- Anti-depressants are also used to treat minor depressive symptoms but the American Food and Drug Administration (FDA, 2004) warned that use of anti-depressants for children and adolescents could perhaps lead to an increased risk of suicide.

Selective serotonin re-uptake inhibitors (SSRI)

- Drugs that interfere with serotonin re-uptake (SSRI) are used in the treatment of depression. They interfere with serotonin levels and affect mood and emotional responses positively in most people. Anti-depressants normally take seven to 14 days to relieve depressive symptoms.
- Currently the most widely used drugs are SSRI. They all increase the level of available serotonin by blocking the reuptake process for serotonin. This results in an increased amount of serotonin in the synaptic gap. The theory is that this increases serotonergic nerve activity leading to improvement in mood in depressive patients.
- SSRI are popular because they have fewer side effects than previous drugs such as the tricyclic antidepressants but not everyone can use SSRI. The most common side effects are headache, nausea, sleeplessness, agitation, and sexual problems.

Neale et al. (2011) conducted a meta-analysis of published studies on the outcome of anti-depressants versus placebo. The study focused on: (1) patients who started with anti-depressants and then changed to placebo, (2) patients who only received a placebo, and (3) patients who only took anti-depressants.

The study found that patients who do not take anti-depressants have a 25% risk of relapse, compared to 42% or higher for those who have been on medication and then stopped it.

According to the researchers, anti-depressants may interfere with the brain's natural self-regulation. They argue that drugs affecting serotonin or other neurotransmitters may increase the risk of relapse. The drugs reduce symptoms in the short term but, when people stop taking the drug, depression may return because the brain's natural self-regulation is disturbed.

Individual treatment

In individual therapy, the therapist works one-on-one with a client. One of the most widely used individual therapies is cognitive behavioural therapy (CBT).

CBT

- The therapy is linked to Beck's explanation of depression (see unit 5.5) where automatic negative thinking is assumed to cause depression. CBT aims to change negative thinking patterns (cognitive restructuring).
- CBT includes around 12 to 20 weekly sessions combined with daily practice exercises, with a focus on helping people with major depression to identify automatic negative thinking patterns and change them.

How CBT works

Step 1: Identify and correct faulty cognitions and unhealthy behaviour (cognitive triad)

The therapist encourages the client to identify thinking patterns associated with depressive feelings. These false beliefs are challenged (reality testing) to give the client the possibility to correct them (cognitive restructuring).

Step 2: Increase activity and learn alternative problem solving strategies

The therapist encourages the client to gradually increase activities that could be rewarding such as sport, going to concerts, or meeting other people (behavioural activation).

- **Paykel et al. (1999)** conducted a controlled trial of 158 patients who had experienced one episode of major depression. The patients received antidepressant medication but some of them also received cognitive therapy. The CBT group had a relapse rate of 29% compared to those who only had medication. Paykel argues that cognitive therapy appears to be effective to prevent relapse, particularly in combination with medication.

How CBT works in treating bulimia (Fairburn, 1997)

CBT is considered the best psychological treatment for bulimia. The treatment involves:

- replacing binge eating with a pattern of regular eating (three planned meals and two planned snacks) and trying to avoid vomiting or other compensatory behaviours
- therapy sessions with the client and later with important friends and relatives who will support behavioural change
- therapy sessions that address both behaviour (e.g. food that provokes anxiety or desire to binge and purge) and cognitive distortions (e.g. concerns about weight and body shape)
- maintenance of the programme and considerations of strategies to prevent relapse.

Hay et al. (2004) studied the effectiveness of CBT in the treatment of bulimia and binge eating. The aim of this meta-analysis was to evaluate the effectiveness of CBT, and a specific form of CBT developed for the treatment of bulimia (CBT-BN).

The study showed that CBT was an effective treatment for eating disorders. CBT was effective in group settings. CBT-BN was particularly effective in the treatment of bulimia but also other eating disorders that involve bingeing.

Wilson (1996) reported that 55% of participants in CBT programmes no longer purged at the end of therapy, and those who continued to purge did so much less (86% reduction in purging).

Fairburn et al. (1995) found that after nearly six years, 63% of the participants in their study had not relapsed.

Interpersonal psychotherapy (IPT)

Klerman et al. (1984) developed IPT as a short-term, structured psychotherapy for depression, but it has been adapted for bulimia nervosa by **Fairburn et al. (1993)**. The aim of the therapy is to help clients identify and modify current interpersonal problems as these problems are assumed to maintain the eating disorder. The therapy does not focus directly on eating disorder symptoms.

Elkin et al. (1989) found that IPT was effective in relieving major depression and to prevent relapse when treatment was continued after recovery.

Fairburn et al. (1993) compared IPT with CBT and found that IPT was less effective than CBT at post-treatment, but follow-up studies after one and six years found that the two treatments were equally effective.

Group treatment

In group therapy, the therapist meets with a group of people (e.g. a family or a group of individuals suffering from the same

disorder). Group therapy is generally less expensive than individual therapy. Group therapy based on mindfulness is becoming increasingly popular and studies indicate that it may be a useful approach.

Mindfulness-based cognitive therapy (MBCT) to treat depression

MBCT is based on Kabat-Zinn's mindfulness-based stress reduction programme (see unit 7.3). The MBCT is developed by **Segal, Williams and Teasdale (2001)**. The aim of this psychosocial group-based therapy is to prevent people becoming depressed again (relapsing) after successful treatment for major depression.

How MBCT works

- MBCT is based on Buddhist meditation and relaxation techniques. These help people to direct their focus and concentrate so they are able to observe intrusive thoughts and gradually become more able to prevent the escalation of negative thoughts.
- The goal of MBCT is to teach people to recognize the signs of depression and adopt a "decentred" perspective, where people see their thoughts as "mental events" rather than something central to their self-concept or as accurate reflections of reality.

Mindfulness-based treatment of bulimia

Proulx (2008) used an eight-week mindfulness-based intervention to treat six college-age women suffering from bulimia. Participants were interviewed individually before and after treatment. They all reported that they could control

emotional and behavioural extremes better after the treatment and had reached a greater self-acceptance. Generally, they felt less emotional stress and were more able to manage stress and the symptoms of bulimia.

Kuyken et al. (2008) Randomized controlled trial of MBCT and anti-depressive medication

- The study investigated the effectiveness of MBCT in a randomized controlled study with 123 participants with a history of three or more episodes of depression. All participants received anti-depressive medication.
- Participants were randomly allocated to two groups. Over the 15-month study, the control group continued their medication and the experimental group participated in an MBCT course and gradually diminished their medication.
- People in the control group who received anti-depressive medication had a relapse rate of 60% compared to the experimental group of 47%. Participants in the MBCT group overall reported a higher quality of life, in terms of enjoyment of daily living and physical well-being. Anti-depressive medication was significantly reduced in the MBCT group and 75% of the patients stopped taking the medication.

Evaluate the use of biomedical, individual and group approaches to treatment

Evaluation of a biomedical treatment of depression

- Drugs are nearly always part of the treatment for severe depression. The biomedical approach to the treatment of depression is under debate. The most common treatment for depression includes drugs. Anti-depressants may reduce depressive symptoms but they have side effects and do not cure patients. Studies indicate that the placebo effect could account for the effectiveness of medication.
- Some researchers and psychiatrists now criticize the heavy use of medication on the grounds that it is not well known how it affects the brain long term (see **Neale et al. 2001**). There is also increasing criticism of the role of pharmaceutical companies and their marketing of anti-depressants, which has led to an increase in the prescription of SSRI.

Leuchter et al. (2002) Changes in brain function during treatment with placebo

- The study examined brain function in 51 patients with depression who received either a placebo or an active medication. An EEG was used to compare brain function in the two groups. The design was double-blind and ran over nine weeks. The study used two different SSRI, which were randomly allocated to the participants.
- Results showed a significant increase in activity in the prefrontal cortex nearly from the beginning in the trial in the placebo group. This pattern was different from the patients who were treated with the SSRI but patients in both groups got better. This indicates that medication is effective but placebo seems just as effective.
- The findings from the study are intriguing. The difference in activity in the brain indicates that the brain is perhaps able to heal itself since there was a positive effect in both groups. Believing they are being treated could be enough for some patients.

Kirsch et al. (2008) Meta-analysis of clinical trials

- This meta-analysis used clinical trials of the six most used anti-depressants (including Prozac) approved between 1987 and 1999.
- The study analysed all clinical trials of anti-depressants submitted to the FDA (US Food and Drug Administration).
- The results showed that the overall effect of new-generation anti-depressant medication (SSRI) was below the recommended criteria for clinical significance. This indicates that placebo may be just as effective.
- The highest effect of the medication was in the most severe cases of depression but the researchers speculate whether this is a real effect or due to a decrease in responsiveness to placebo rather than an increase in responsiveness to medication.
- According to the researchers, the placebo effect may account for any observed effect and they are very sceptical about the increasing use of anti-depressants on the basis of the results of the clinical trials.

Evaluation of an individual approach to the treatment of depression

- Individual treatments are normally effective. Cognitive theories have been criticized for focusing too much on symptoms (distorted thinking patterns) rather than causes of depression.
- The combination of behavioural techniques with cognitive restructuring in CBT seems to be effective, even in the absence of medication (**Luty et al. 2007**). Studies that combine medication with CBT have good results, see unit 5.7 (**Paykel et al. 1999**).

Luty et al. (2007) Randomized controlled trial of IPT and CBT

- The study investigated the relative effectiveness of the two treatments for major depression.
- A 16-week therapy with 8 to 19 individual sessions was attended by 177 patients diagnosed with major depression. Patients were randomly allocated to either CBT or IPT. They did not receive medication and those who eventually decided to use it were not included in the study.
- Generally the results showed no difference in effect of the two forms of psychotherapy but CBT was more effective in severe depression. Only 20% of patients with severe depression responded to IPT, whereas 57% of patients responded to CBT.

- The results indicate that psychotherapy alone could relieve symptoms of depression even when no drugs are given.

Elkin et al. (1989) Controlled outcome study of treatment for depression.

- The study is one of the best controlled outcome studies in depression. It involved 280 patients diagnosed with major depression who were randomly assigned to either (1) an anti-depressant drug plus the normal clinical management, (2) a placebo plus the normal clinical management, (3) CBT or (4) IPT. The treatment ran for 16 weeks and the patients were assessed at the start, after six weeks, and after 18 months.

- The results showed a reduction of depressive symptoms of over 50% in the therapy groups and in the drug group. Only 29% recovered in the placebo group. There was no difference in the effectiveness of CBT, IPT or anti-depressant treatment. This indicates that psychotherapy might be an alternative in some cases.
- The recovery rate for therapy (psychological and drug) was only 50% in this study so neither of the treatments can guarantee recovery for all patients.

Evaluation of a group approach to treatment of depression

- Group therapy has been used to treat depression but it may not be appropriate as the only therapy and it should only be used when clients are positive about treatment in a group.
- Modern forms of group therapy include ideas from Buddhism and ideas from cognitive therapy. It seems to be a promising way to treat depression but it may be suitable only for clients who are not severely depressed.

McDermut et al. (2001) Meta-analysis on effectiveness of group therapy for depression

- The study was a meta-analysis based on 48 studies published between 1970 and 1998. The patients' mean age was 44 years and 78% of patients were women. All but one study included a cognitive and/or behavioural treatment group.
- Results showed that 45 of the 48 studies reported that group psychotherapy was effective for reducing depressive symptoms. The overall results showed that group psychotherapy was more effective than no treatment around 19 weeks after the end of treatment. Nine studies showed that individual and group psychotherapy were equally effective.
- The conclusion was that there is sound empirical support that group therapy is effective for relieving depressive symptoms. **Truax (2001)** commented on the results saying that group therapy should only be used when clients are positive about treatment in a group. The meta-analysis did not include severely depressed and suicidal patients in the study so it is not possible to conclude anything in relation to this group.

Exam Tip Kuyken et al. (2008) on MBCT in unit 5.7 can also be used to answer a question on the effectiveness of group therapy.

Discuss the use of eclectic approaches to treatment

Eclectic approaches to the treatment of depression

- The most common approach to the treatment of depression is antidepressive medication. This often relieves the depressive symptoms although it may take weeks before there is an effect and dropout rates are quite high because of the adverse effects of anti-depressants.
- Although nearly 50% to 60% of depressed outpatients experience an improvement in mood to the first trial of antidepressants, only 1 in 3 patients will experience a full and complete recovery with no symptoms (Keller et al. 2004). The risk of relapse is also high and there is risk of repeated depressive episodes (chronic depression). The combination of psychotherapy and drugs seems to be particularly valuable in the prevention of relapse.

Klerman et al. (1974) Treatment of depression by drugs and/or psychotherapy

- The aim of this controlled study was to test the efficacy of treatment with anti-depressants and psychotherapy, alone or in combination.
- Participants were 150 females diagnosed with depression. Patients were divided into three groups: (1) anti-depressants alone, (2) anti-depressants and psychotherapy, and (3) no medication but more psychotherapy or (4) placebo and no psychotherapy.
- The results showed that relapse rates were highest for patients in the placebo group alone (36%). The group with anti-depressants alone had a relapse rate of 12%; the



psychotherapy (IPT) alone had a relapse rate of 16.7%; combination of drug and IPT had a relapse rate of 12.5%.

- There was no significant difference between drug therapy alone or drug therapy in combination with psychotherapy.

This study could also be used in unit 5.7 to address the effectiveness of biological treatment and individual treatment of depression.

Pampallona et al. (2004) Meta-analysis of efficacy of drug treatment alone versus drug treatment and psychotherapy in depression

- The aim of the study was to analyse whether combining anti-depressants and psychotherapy was more effective in the treatment of depression.
- 16 randomized controlled studies were conducted including 932 patients taking antidepressants only and 910 receiving combined treatment. The patients had all been randomly allocated to the treatments.
- The results showed that patients in combined treatment improved significantly more compared to those receiving drug treatment alone. This was particularly true in studies that ran over more than 12 weeks and there was also a significant reduction in dropouts.

Why eclectic approaches could be more efficient than medication alone

- There is always a risk that patients stop taking their medicine (e.g. anti-depressants). This could be because the patient feels somewhat better after a while and then stops, or it could be because he or she experiences too many negative side effects.
- According to Pampallona et al. (2004) this could be a very good reason for the clinician to combine anti-depressants with psychotherapy. Their review of randomized controlled trials shows that the combination of drugs and psychotherapy generally leads to greater improvement. The study also showed that psychotherapy helps to keep patients in treatment.

5.10

Discuss the relationship between etiology and therapeutic approach in relation to one disorder

- **Etiology** means explaining the *cause* of a disorder. This is often very difficult within abnormal psychology. There are no simple explanations of complex psychological disorders. Logic suggests that the cause of a disorder should dictate the treatment. This is done in medicine but it is not possible in the case of psychiatric disorders such as major depression because the causes of disorders are not well known and cures have yet to be found.
- Scientific research has failed to show a clear link between serotonin levels and depression. The fact that anti-depressant drugs like SSRI can regulate serotonin levels and produce an effect does not mean that low serotonin levels cause depression.

Etiology and therapeutic approach in major depression

- Treatment of major depression often involves anti-depressant medication that interferes with neurotransmission (e.g. serotonin and dopamine) in the brain. This can be seen as an attempt to regulate what is believed to be an imbalance in the serotonin system.
- Some psychiatrists question the usefulness of anti-depressants that interfere with serotonin balances in the brain on the grounds that:
 - ❑ the serotonin system in the brain is very complex and not much is known about the drugs' long-term effect
 - ❑ the drugs do not cure depression and have side effects
 - ❑ studies show that placebo might be just as effective
 - ❑ psychotherapy (particularly CBT) is just as effective and in some cases more effective.
- **Henninger et al. (1996)** performed experiments where they reduced serotonin levels in healthy individuals to see if they would develop depressive symptoms. The results did not support that levels of serotonin could influence depression and they argued that it is necessary to revise the serotonin hypothesis.

Etiology: the serotonin hypothesis

- The serotonin hypothesis suggests that depression is caused by low levels of serotonin in the brain (**Coppen, 1967**).
- Anti-depressants in the form of SSRI block the re-uptake process for serotonin. This results in an increased amount of serotonin in the synaptic gap. The theory is that this improves mood.
- SSRI such as Prozac, Zoloft and Paxil are now among the most sold anti-depressants, and the drug companies spent millions of dollars on advertising campaigns all over the world. This has been taken as indirect support of the serotonin hypothesis. According to **Lacasse and Leo (2005)** this is an example of backward reasoning. Assumptions about the causes of depression are based on how people respond to a treatment and this is logically problematic. For example, it is clear that aspirin can cure headaches but this does not prove that low levels of aspirin in the brain cause headaches.

Elkin et al. (1989) Controlled outcome study of treatment for depression

- The study is one of the best controlled outcome studies of depression. A sample of 280 patients diagnosed with major depression were randomly assigned to either an anti-depressant drug plus the normal clinical management, a placebo plus the normal clinical management, CBT (cognitive-behavioural therapy) or IPT (interpersonal therapy). The treatment ran for 16 weeks and the patients were assessed at the start, after 6 weeks, and after 18 months.
- The results showed a reduction of depressive symptoms of over 50% in the therapy groups and in the drug group. Only 29% recovered in the placebo group. There was no difference in the effectiveness of CBT, IPT or anti-depressant treatment. For the most severely depressed patients, medication and clinical management was most effective in reducing symptoms but this does not prove that serotonin causes depression.